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DIRECTIVE NUMBER 167

COVERAGE OF MENTAL HEALTH SERVICES

It has come to my attention that the policy form filings of some accident & health insurance companies, health maintenance organizations, and self-insurers are failing to comply with the statutory requirements of LRS 22:669. Charged with the duty of administering the provisions of the Louisiana insurance code, and all other Louisiana laws applicable to licensed insurers, I hereby direct every insurance company, health maintenance organization, and self-insurer providing group major medical health coverage in this state to assure all insurance products filed for approval with the department are brought into full compliance with the following statutory requirements:

LRS 22:669 states:

"Severe mental illness and other mental disorders; policy provisions; minimum requirements; group, blanket, and franchise policies

A. (1)(a) Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or other agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type in this state, including a group insurance plan, a self-insurance plan, and the Louisiana State Employees Group Benefits Program, delivered or issued for delivery in this state on or after January 1, 2000, shall include benefits payable for the treatment of severe mental illness under the same circumstances and conditions or greater as benefits are paid under those policies, contracts, benefit plans, agreements, or programs for all other diagnoses, illnesses, or accidents.

(b) For purposes of this Section, "severe mental illness" shall include any of the following diagnosed severe mental illnesses:

(i) Schizophrenia or schizoaffective disorder.
(ii) Bipolar disorder.
(iii) Pervasive developmental disorder or autism.
(iv) Panic disorder.
(v) Obsessive-compulsive disorder.
(vi) Major depressive disorder.
(vii) Anorexia/bulimia.
(viii) Asperger's Disorder.
(ix) Intermittent explosive disorder.
(x) Posttraumatic stress disorder.

(xi) Psychosis NOS (not otherwise specified) when diagnosed in a child under seventeen years of age
(xii) Rett's Disorder.
(xiii) Tourette's Disorder

(2)(a) Any issuer of a group, blanket, or franchise policy, contract, benefit plan, agreement, or program specified in Paragraph (1) of this Subsection shall also offer to the policyholder an optional provision in the policy, contract, benefit plan, agreement, or program which states that benefits shall be payable for the treatment of mental disorders other than severe mental illness as defined in Paragraph (1) under the same circumstances and conditions as benefits are paid under those policies, contracts, benefit plans, agreements, or programs for all other diagnoses, illnesses, or accidents.

(b) If the policyholder elects not to purchase this optional coverage, the issuer shall not be required to notify the policyholder in any renewal, reinstatement, or modified policy, contract, benefit plan, agreement, or program as to the availability of the optional coverage. However, the policyholder may request the optional coverage in writing on any anniversary date of the policy, contract, benefit plan, agreement, or program.

(3)(a) The provisions of this Section shall apply only to group, blanket, and franchise policies.

(b) The provisions of this Section shall not apply to individually underwritten health insurance plans; short term, limited duration health insurance policies; and individually underwritten limited benefit and supplemental health insurance policies.

(4) These benefits shall be payable when the treatment or services are rendered by a physician licensed under the provisions of R.S. 37:1261 et seq., psychologist licensed under the provisions of R.S. 37:2351 et seq., or when the treatment or services in connection with diagnostic consultation provided by a physician are rendered by a licensed clinical social worker licensed under the provisions of R.S. 37:2701 et seq., who is a member of a national clinical social work registry.

(5) A policy, contract, benefit plan, agreement, or program shall be in compliance with the requirements of Paragraph (1) of this Subsection if it includes the following benefits:

(a) Forty-five inpatient days per covered individual per calendar year. However, a policy, contract, benefit plan, agreement, or program may provide a method to allow a covered individual to exchange two days of partial hospitalization or two days of residential treatment center hospitalization for each inpatient day of treatment.

(b) Fifty-two outpatient visits per covered individual per calendar year, including the intensive outpatient program. However, a policy, contract, benefit plan, agreement, or program may provide a method to allow a covered individual to exchange one inpatient day of treatment for four outpatient visits or exchange four outpatient visits for one inpatient day of treatment.

B Whenever any such policies, contracts, programs, or plans provide for the reimbursement of health-related services that can be lawfully performed by a licensed clinical social worker, licensed under the provisions of R.S 37 2701 et seq., the insured or other person entitled to benefits under such policy, contract, program, or plan shall be entitled to reimbursement for such services performed by a board-certified social worker notwithstanding any provisions of the policy, contract, program, or plan to the contrary, provided the social worker is in collaboration and continuing consultation with a physician licensed by the Louisiana State Board of Medical Examiners who assumes the responsibility for the total health of the patient.

C. No policy, contract, benefit plan, agreement, or program issued or entered into pursuant to this Section shall contain any provision for a waiting period in excess of sixty days from its effective date before benefits are payable for the treatment of severe mental illness or other mental disorders.

D. Nothing in this Section shall be construed to prohibit management of the provision of benefits for mental disorders through such methods as preadmission screening prior to the authorization of services or any other mechanism designed to limit coverage for services for mental disorders only to those deemed medically necessary by a licensed mental health professional."

Under Subsection A (1) the insurance policy, certificate or contract is required to include benefits payable for the treatment of severe mental illness under the same circumstances and conditions or greater as benefits are paid...for all other diagnoses, illnesses, or accidents. This language clearly establishes a requirement for such benefits to be covered under the same circumstances and conditions or greater as benefits are paid under those policies, contracts, certificates, benefit plans, agreements, or programs for **all** other diagnoses, illnesses, or accidents.

Furthermore, health policies are only in compliance if the inpatient and outpatient benefit limitations of Subsection (5)(a)(b) are elected and included under the same deductible, coinsurance, and co-payment amounts applicable to other inpatient and outpatient benefits. Therefore, a plan that elects the Subsection 5(a)(b) provisions cannot subject severe mental illness benefits to lower calendar year or lifetime benefit maximum amounts or higher deductible, coinsurance, or co-payment requirements in order to avoid compliance with the statutory requirements. For clarifications purposes, the limitations on inpatient and outpatient visits as enumerated in Subsection (5)(a)(b) apply only to the severe mental illness benefits.

The requirements of Subsection A (2) mandate optional provision of coverage for the treatment of **all mental disorders** under major medical group insurance products, under the same circumstances and conditions as benefits are paid...for all other diagnoses, illnesses, or accidents. If the full coverage option is elected by the policyholder, the insurance policy, certificate, contract, benefit plan, agreement or program is required to include mental health benefits under both inpatient hospital coverage and outpatient coverage and, cannot subject severe mental illness benefits to lower calendar year or lifetime benefit maximum amounts or higher deductible, coinsurance, or co-payment requirements in order to avoid compliance with the statutory requirements.

In addition to deductible, coinsurance and co-payment requirements, examples of "same circumstances and conditions" also include uniform availability of any out-of-network or point-of-service coverage otherwise provided for in the insurance policy, certificate, contract, benefit plan, agreement or program.

The mandated offer of full coverage does not require or prohibit the issuer from offering additional coverage options, including lesser benefits for the treatment of mental disorders, as long as the offer of full coverage for the treatment of mental disorders is one of the options offered and, any options for lesser benefits include the minimum benefits required for treatment of severe mental illnesses.

Pursuant to Subsection A (3), the provisions of this Section apply only to group, blanket, and franchise policies as those types of health and accident insurance are defined in LRS 22:215 A. Individually underwritten major medical insurance plans are excluded, including any individual policies issued under franchise health and accident insurance unless such individual policies are issued to all members without individual underwriting.

Please Be Governed Accordingly.

BY: 

J. ROBERT WOOLEY
ACTING INSURANCE COMMISSIONER